MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 08-19

Distribution: Local Health Departments

Issued: April 1, 2008

Subject: CSHCS Non-Emergency Medical Transportation

Effective: May 1, 2008

Programs Affected: Children's Special Health Care Services (CSHCS)

A non-emergency medical transportation provider (e.g., Ambu-Cab, Medi-Van, vans operated by medical facilities or public entities, taxis, etc.) may be authorized to provide transportation to Children's Special Health Care Services (CSHCS) clients who do not have adequate access to public or private transportation for the purpose of obtaining medical care.

Effective May 1, 2008, requests for non-emergency medical transportation providers must be prior approved by the Local Health Department (LHD) on the Non-Emergent Medical Transportation Authorization and Verification form (MSA-0709). A copy of the MSA-0709 is included as an attachment. Payment is made directly to the provider by MDCH.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

Michigan Department of Community Health
Children's Special Health Care Services (CSHCS)

NON-EMERGENT MEDICAL TRANSPORTATION AUTHORIZATION and VERIFICATION

IMPORTANT:

- This form is issued by the LHD to authorize non-emergency transportation, and serves as documentation for the transportation provider when billing for the service.
- This Non-Emergent Medical Transportation is available to clients who do NOT have access to standard transportation or a vehicle (public or private), sufficiently equipped for the needs of the client.
- The client must have current CSHCS eligibility on the date of service and must be visiting a CSHCS approved provider for services relating to the client's CSHCS diagnosis.
- The client must also meet at least one of the following criteria:
  1. Wheelchair dependent
  2. Bed bound
  3. Medically dependent upon life sustaining equipment that cannot be accommodated by standard transportation.
  4. Unable to access public or private transportation for the purpose of obtaining medical care.

SECTION 1 – To be completed by the Local Heath Department (LHD): *Type or Print Firmly*

Name of Client		Client ID Number	DATE(S) OF TRANSPORTATION:
Date of Birth	County of Client	Client Social Security Number	
Provider / Clinic Name		Provider / Clinic Phone Number **( )**	
LHD Agency Name		LHD Authorizing Signature	Date Signed
LHD Agency Phone Number **( )**			

SECTION 2 – Parent / Guardian Agreement:

I have read and agree to the following: • The doctor or clinic must provide proof of the visit BEFORE CSHCS will make payment to the Transport Company. • If proof is NOT provided, payment for this transport will be the responsibility of the parent / guardian who requested the transport.	Parent / Guardian Signature	Date Signed

SECTION 3 – To be completed by the Medical Office or Clinic Personnel:

Purpose of Appointment				
Name of Doctor or Clinic			I verify that the client named above was seen at this office on the above date.	
Doctor / Clinic Address			Office / Clinic Personnel Signature	Date Signed
City	State	ZIP Code		

SECTION 4 – To be completed by the Transport Company:

- Submit the WHITE copy of this form with all required signatures.
- Include an itemized invoice including your FE ID number, number of loaded miles, and description of trip (round trip or one way).
- A W-9 & Payee Registration must be on file with the State of Michigan.
- Mail these items to:

  PAYMENT EXCEPTIONS UNIT
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30688
  LANSING MI 48909

Name of Transport Company	Transport Company Representative Signature	Date Signed
We agree to accept CSHCS payment as PAYMENT IN FULL for this transport.		

AUTHORITY: Title V of the Social Security Act
COMPLETION: Is Voluntary, but is required if CSHCS Program payment is desired.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

MSA-0709 (3/08)

COPY DISTRIBUTION: (WHITE) - Attach with invoice (PINK) - Parent Copy
(YELLOW) - Transport Company (GOLDENROD) - Local Health Department